MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Wednesday, April 12, 2006
1:30 PM
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Wednesday, April 12, 2006, at 1:30 P.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair, Senators Austin Allran, Janet Cowell, Jeanne Lucas, Vernon Malone, and William Purcell and Representatives Jeff Barnhart, Bob England, Carolyn Justice, and Fred Steen. Advisory member, Senator Larry Shaw also attended.

Kory Goldsmith, Andrea Russo, Jennifer Hoffman, Shawn Parker and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order, welcoming members and guests. He asked for a motion to approve the minutes from the March 22nd meeting. Senator Malone made the motion and the minutes were approved.

Kory Goldsmith, staff attorney, reviewed the follow-up questions from the March 22nd meeting. (See Attachment No. 2) She reviewed residency requirements by Medicaid; addressed the use of target populations in other states; explained a chart showing contributions by each county to its LME; and answered questions regarding Utilization Review (UR) and Screening, Triage, and Referral (STR). Carol Shaw from Fiscal Research answered a question regarding how it was determined if care should be given to an illegal alien at an emergency room. She said the federal requirement is intended to protect hospitals that are required to take anyone coming through an emergency room and determine what their needs are, so it only applies to emergency rooms.

Representative Insko recognized two nationally known experts, Val Bradley with the Human Services Research Institute and Steve Day from Technical Assistance Collaborative, to present an outline of qualitative measures that the federal government and states like North Carolina are utilizing to measure success. Copies of their bios were provided. (See Attachment No. 3) She said the information provided by them was the result of funding from the NC Council on Developmental Disabilities under an "Ecology for Change" grant.

Ms. Bradley said she and Mr. Day would provide an overview of what is happening nationally regarding the measurement of performance. (See Attachment No. 4) She said that because of the complexity of the system, performance measurements were crucial.

The Centers for Medicaid and Medicare Services (CMS), now a major partner in the funding of services, have specific expectations of what quality management should look like in each state that has home and community based waivers. She reviewed the CMS framework to be placed over every state system. She emphasized the importance of data, what is being done with it and how it is being used to create change. Ms. Bradley said it was important that the outcomes show how the money is invested and that the bottom line was the impact on individuals and families with disabilities. She stressed the need to see that public funds are being invested to best support and improve the quality of people's lives. She listed several national performance schemes with the ability to compare North Carolina's performance with other states. Ms. Bradley said the hallmarks of reform have led to the advancement of best practice and the standardization of best practice around the state.

Mr. Day spoke on the domains of performance saying that he and Ms. Bradley looked at some of the national work that had been done on outcome and performance indicators and translated that to the situation in North Carolina. Access, one of the most important issues, determines how the priority populations get services, how easy it is to get services, how long it takes to get services and is enough of the population being served. He said that North Carolina uses access performance standards for LMEs. He told of other domains used around the country including consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management system, consumer rights and respect, stakeholder involvement and governance, system efficiency and effectiveness, and prevention and early intervention. Mr. Day indicated that most of performance measurements start from the point of view of the consumer since they can best tell how the system is working for them. He said a good quality management system was an important part of the overall accountability structure. Mr. Day also said local government officials should be engaged in the governance of the system. Looking at outcomes compared to how much is being spent provides information on efficiency and effectiveness. He said the analysis comes together when Legislators are able to determine if the investments in best practice services are producing good outcomes for people.

Mr. Day said that North Carolina already collects most of the data mentioned in the various domains. One issue is how to take the information already collected and put it together in a way that answers questions by those in the Legislature and the general public regarding system performance. He said that there is a lot of information in the claims files; demographic information in the client data warehouse; consumer outcomes indicators; quarterly and annual reports from the LMEs; and the National Core Indicators pilot project.

Ms. Bradley shared data from North Carolina collected as part of the National Core Indicators regarding people with DD in the service system. The three domains included community inclusion, decision-making, and service coordination. She referenced charts that compared North Carolina data to national benchmarks. In conclusion, she said that North Carolina has the data, but needs to be open to an analysis of the data and opening

up that data to interpretation among stakeholders. Legislators, she said, need to collect it, analyze it, use it, and act on it.

Members addressed their concerns regarding the amount of paperwork that would be generated in order to collect the data. Mr. Day said that there were ways to consolidate how information is collected, such as using more standardized instrumentation at the lowest level, and collecting information as a normal part of business. Quality Management is the key tool in telling stakeholders if the system is performing the way it should.

Flo Stein, Chief of the Community Policy Management Section with the Division of MHDDSAS, gave a brief overview of how the Division is gathering and using data and other indicators. (See Attachment No. 5) She said that one of the most significant accomplishments had been to establish a team within the Division that focuses entirely on Quality Management and Performance. She explained that the Division had the data and could produces reports, but the real challenge was to use the data to make decisions. Ms. Stein reviewed the objectives of Quality Management. Spencer Clark, Director of Operations and Clinical Services with the Division, gave an overview of the reports to show the kind of data and how it might be presented. He said, for example, that the LME Performance Contract Quarterly Report, reports on 31 different areas of management by an LME such as service, development, management, fiscal, and information systems. Mr. Clark referenced websites where annual reports could be reviewed. A federal website shows how North Carolina measures compare to the national average. He said that LME reports and provider base reports can be obtained by request.

Mr. Clark then reviewed several charts showing data on mental health and substance abuse treatment measures; outcomes on the use of tobacco, alcohol, and marijuana; and the results of pre and post treatment for substance abuse clients. He also referenced the Quarterly Report on Level 2 and 3 Incidents in LMEs. LMEs and providers report on deaths, restrictive interventions, seclusion, allegations of abuse, injuries, medication errors, and others. Mr. Clark said that the incidents were monitored very carefully by the LMEs and that the LME worked with the providers when necessary. The Consumer Satisfaction Report, generated annually, also provided an array of domains.

Ms. Stein said the consultants' presentation indicated what should be done and that North Carolina has done a very good job of measuring performance, but needs to do more analysis in order for Legislators to make informed decisions about funding and policy. Mr. Moseley, Director of the Division, added that it was important when tracking data to have a baseline. He added that with the implementation of the new services, the baseline is just now being established.

Regarding legislative proposals, Senator Nesbitt explained that the Committee would not be making recommendations today, but would review the suggested proposals. Kory Goldsmith, staff attorney, began with an overview of the findings of the initial text. (See Attachment No. 6) The report was broken into subject area, the first addressed State funding for all the different service areas and the funding allocation of State dollars to the

LMEs. The total expenditure of state and federal funds for FY04/05 was $l.1 billion, not including Medicaid funds flowing to the community or providers. She said that of the total funds appropriated by the State, $580. 5 million, 53% were state funds. She gave a breakdown of the total amount spent by the State in FY2005 on each disability and said that a report generated by the National Alliance of Mental Illness ranked North Carolina 43rd among states in its per capital spending for mental health. The report said an additional $285.5 million would bring North Carolina to 88.8% of the national per capita for FY2002-03. LOC staff had previously estimated the total need to be $172.5 million based on current State spending per consumer. The highest service dollar allocation per capita catchment was $56.80 and the lowest was $24.39 for 2005. The State average per capita is $37.20 and the median is $41.50. Andrea Russo from Fiscal Research explained recommendations related to funding, including appropriating $49 million in recurring funds to be used to bring the state service dollar per capita to at least $41.50. A spreadsheet showing the allocation to each LME was distributed. (See Attachment No. 7) Also, those LMEs not receiving funding would have the flexibility to shift up to 5% of their funds between age and disability categories. It was noted that this recommendation addressed the disparity in the amount of State service dollars going to LMEs to provide indigent care. Leza Wainwright, Deputy Director with the Division, noted that the two preliminary reports from the Division addressing some of the funding issues would be ready to present to the LOC the first week in May.

Ms. Goldsmith then reviewed the findings surrounding the issue of building community capacity and financing reform. She explained the purpose of the Mental Health Trust Fund and the critical element of appropriate housing and how it is specific to community capacity. She also explained the apparent discrepancy in current law regarding the use of recurring savings from the downsizing of the State psychiatric hospitals. To date, approximately $15 million has been realized in recurring dollars from downsizing with less than $4 million being contributed to debt services. Ms. Russo said the first recommendation was to direct DHHS and the N.C. Housing Financing Agency to finance 400 independent and supportive living apartments for individuals with disabilities at a cost of approximately $23 million in non-recurring funds. The other recommendations were to appropriate $20 million (non-recurring) to the MH Trust Fund to build community capacity, $5,580,000 (recurring) for hospital debt service, and to reconcile the provisions of the Psychiatric Hospital Financing Act and the 2005 Budget so that debt service is paid from appropriations and savings from downsizing is placed in the MH Trust Fund to build community capacity.

Members were concerned that 400 units would not adequately address the needs of housing. Representative Insko said that there were other efforts including money in the budget last session for housing and federal funds were drawn down to be used for transitional housing. Ms. Russo said there were waiting lists of first come first serve. For example, the Housing Authority has a waiting list for their Rent Assist Programs. A person living in one of the units could stay indefinitely as long as the individual met the terms of the lease.

Ms. Goldsmith then explained the findings under facility-based and non-facility based crisis services. She first reviewed the statutes surrounding crisis services. Ms. Goldsmith reminded members that they heard in an earlier meeting that crisis services are not consistent across the State and area authorities and county programs do not have sufficient "start-up" funds to establish crisis services. There is also concern that the approved rate for psychiatrists will not be sufficient to assure services and there is evidence that there is a regional shortage of psychiatrists. The report recommended appropriating $10.5 million (non-recurring) to be used by LMEs to establish a continuum of crisis facilities regionally and crisis services locally and an undetermined amount to hire a consultant to assist LMEs with developing and implementing start-up crisis services. It was further suggested to organize the LMEs into 21 crisis regions based on the existing Geriatric Specialty team configurations. (See Attachment No. 8) Also recommended was the appropriation of $9 million (recurring) to create a fund to be used by LMEs to pay for non-Medicaid reimbursable crisis (core) services and an appropriation of $9 million (recurring) for LMEs to ensure access to core psychiatrist services. The final recommendation in this section was to appropriate $1 million (recurring) to AHEC/Rural Health Program to develop a program (including loan repayment) to recruit psychiatrists to rural and underserved areas to provide community services.

Ms. Goldsmith continued with the findings for the Department of Health and Human Services and the Division of MHDDSAS. The State Plan has not functioned as the strategic planning document that the General Assembly intended. Also, the Secretary has not adopted rules required of her under the powers of duties in G.S. 122C-122.1 and policy decisions implemented have increased distrust among stakeholders. The Division has allowed the time-lines for implementation to become disconnected, there has not been sufficient technical assistance to the LMEs, and the Division has not imposed "State-wideness" in situations where uniformity was necessary. Recommendations included having the Department review all the State Plans and produce a single cumulative statement of what is still applicable under the State Plan. Also, the Department should identify those directives contained in the Plan and other communications by the Division that must be adopted by administrative rule in order to be enforceable. Also, the Department should amend the State Plan to clarify that it is a strategic document setting a course of action for the State for a 3 year period of time, indicating specific goals and benchmarks, identify data to measure those goals, and report annually on the progress of the reform system. Other recommendations included: amending G.S. 122C-112.1 to clarify that the Secretary and the Division have a duty to provide technical assistance to the LMEs; appropriate $425,000 (non-recurring) to hire a consultant to assist the Department with the strategic planning necessary to develop the revised State Plan; and to appropriate $425,000 (non-recurring) to hire a consultant to study and make recommendations to increase the capacity of DHHS to implement system reform successfully The final recommendation in this section was to appropriate $425,000 (non-recurring) to hire a consultant to assist the Division and LMEs with standardizing the utilization management functions for non-Medicaid services, developing LME expertise to undertake utilization management for Medicaid services by

July 1, 2009, developing a standardized LME operating procedure, and implementing other LME management functions.

Continuing, Ms. Goldsmith reviewed findings for the LMEs. She said that the functions of the LME had changed significantly, making them managers of services rather than providers of services. Statutes are not clear as to what the management roles and duties are and the role of the LME to conduct utilization review (UR) is not clear. The intent of the General Assembly was to have 20 LMEs by January 1, 2007. There are currently 29 LMEs. The Oversight Committee finds that additional consolidation is needed to accomplish system reform. The LOC also finds that the success of an LME is dependent on a strong director and sound financial management. Recommendations included: amend Chapter 122C to clearly articulate those administrative and managerial functions that are the responsibility of the LME including UR, STR, provider endorsements and quality assessment; direct the Division to reexamine the LME cost model so it adequately reflects the LME functions in the first recommendation and allocate funds accordingly; amend Chapter 122C so that by July 1, 2007 all LMEs would have a catchment area that includes at least 5 counties or a population of at least 200,000 or lose 10% of administrative funding each year until merger is accomplished; direct the Office of State Personnel to develop job classifications for area directors and finance officers by December 1, 2006; amend G.S. 122C-119.1 to specify that board members must receive at least 6 hours of training annually and appropriate $20,000 (recurring) to the Division, the Council of Community Programs, the Association of County Commissioners and School of Government at UNC-CH to implement the training; and modify area board membership to specify term limits for members and increase participation by individuals with business and financial backgrounds.

Members voiced concern regarding the recommendation for an LME to have 5 counties or a population of 200,000. Senator Nesbitt said that there were very few that did not already comply with this requirement. He said under the current cost model for LMEs, those under 200,000 receive more money per person than those that consolidate. The 5 LMEs that do not meet the 200,000 criteria are Catawba, Johnston and Pitt (all single county) and (2 multi-county) Roanoke, Chowan and Neuse.

Ms. Goldsmith then reviewed the findings regarding consumers. The General Assembly recognized the importance of consumer involvement in the reform system. The LOC finds that it is important to focus and formalize the advisory role of consumers in system reform and recognizes that the representation on the State CFAC should be broadened to include appointments by other stakeholders. Recommendations included: codifying local CFACS and clarifying and focusing their roles and responsibilities; codifying the State CFAC and providing that of the 21 members, 9 be appointed by the Secretary, 3 by the President Pro Tempore, 3 by the Speaker, 3 by the Council of Community Programs, and 3 by the Association of County Commissioners; and appropriate $1,200,000 (recurring) to implement the MHDDSAS Consumer Advocacy Program as enacted in 2001.

Regarding providers, Ms. Goldsmith said that the providers were one of the major components in system reform and service delivery. In order for system reform to work,

there must be high quality services in sufficient quantity across the State. Circumstances have made it difficult for providers to survive financially. Complications have resulted from an unclear definition of what constitutes a clean claim causing confusion in what is required for billing and causing delays in payment to providers. She also said that it was important that all providers are able to deliver new services based on evidence best practices and said that the Division had developed a Provider Action Agenda to address many of these issues, but the authority to implement the procedures should be explicit. Recommendations included: directing the Division to adopt a uniform provider contract, billing and claims forms, and uniform person centered plan forms, standardizing the definition of a clean claim, standardizing denial codes, standardizing policy for coordination of benefits, and developing a system to provide timely outcome data to LMEs; and directing the Division to identify other areas of standardization without undermining the management authority of LMEs and identifying and eliminating processes and procedures that are duplicative; and appropriating $425,000 (non-recurring) to hire a consultant to provide technical assistance and oversight to providers and LMEs to ensure that new services are being delivered with fidelity to the model.

Senator Nesbitt asked members to review the document and to make changes or recommendations so staff could revise the report in time for the next meeting. He said the total amount of the proposal amounted to $104,598,000in recurring funds and $55,000,000 in non-recurring funds. He told members of an organized group of physicians in his area, that developed a program called *Project Access* that guarantees a primary care physician to everyone in the county. This group has proposed a pilot program on integrated care that will be included in the recommendations. He questioned why mental health was not under the Health Department.

Senator Malone suggested that a statement be included in the narrative recognizing that the Department had not been given adequate funding to make system reform succeed. Senator Nesbitt added that there had also been a recession that created additional problems.

Before adjourning, Senator Nesbitt told members there were letters at the front of the room for them from Jack Lordon and the N.C. Psychiatric Association. (See Attachments No. 8 and 9)

There being no further business, the meeting adjourned at 4:40 PM.

Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant